MONTANA DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
DIVISION OF QUALITY ASSURANCE
NURSE AIDE REGISTRY
PO BOX 202953
HELENA MT 59620-2953

NURSE AIDE AND HOME HEALTH REGISTRY RENEWAL APPLICATION

SECTION I: APPLICANTS PERSONAL INFORMATION

(PLEASE PRINT OR TYPE)

Name: _____
Last First Middle Initial Maiden Name

Current Address : _____

_____
City State Zip Code

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Date of Birth: _____ Male/Female: _____ Soc. Security Number: _____

Type of Certification you are applying for: (check one only) CNA _____ CNA & HHA _____

SECTION II: EMPLOYMENT INFORMATION

IT IS VERY IMPORTANT THAT YOU PROVIDE THE DATE YOU WERE LAST EMPLOYED PROVIDING NURSING SERVICES. THIS INFORMATION WILL BE USED TO DETERMINE YOUR CERTIFICATION STATUS, FAILURE TO PROVIDE THIS INFORMATION WILL RESULT IN YOUR RECERTIFICATION NOTICE NOT BEING ISSUED.

List all Employer (s) Name, Address and Phone Number for whom you worked in the past 2 years **PROVIDING NURSING SERVICES.**

Employer(s) Name and Address	Employer Phone Number	Date Last Worked as CNA/HHA DATE MUST BE VERIFIED BY EMPLOYER
1.		From Mo/Yr To Mo/Yr
2.		
3.		

_____ _____
APPLICANT□S SIGNATURE DATE

YOU MUST PRESENT THIS FORM TO YOUR **CURRENT OR FORMER** EMPLOYER FOR WHOM YOU LAST WORKED PROVIDING NURSING RELATED SERVICES FOR VERIFICATION OF EMPLOYMENT, YOUR RENEWAL WILL NOT BE PROCESSED UNLESS YOUR EMPLOYMENT IS VERIFIED ON THE REVERSE SIDE OF THIS FORM.

If you have any questions or need assistance in completing this form, please feel free to call the Nurse Aide Registry at (406)-444-4980.

FOR OFFICIAL USE ONLY: SECTIONS III AND IV TO BE COMPLETED BY EMPLOYER ONLY

SECTION III: **EMPLOYER / FACILITY INFORMATION**

Employer's / Facility Name: _____

Employer's / Facility Address: _____

_____
City State Zip Code

Type of Facility (Please check one of the following)

Licensed Health Care Facility or Agency _____

Physicians Office or Clinic _____

Private Duty _____

Other _____ (Please indicate what type of entity)

_____

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SECTION IV: **VERIFICATION OF EMPLOYMENT**

THE EMPLOYEE LISTED ON THE REVERSE SIDE OF THIS FORM (either currently or previously) HAS WORKED IN YOUR FACILITY FOR A MINIMUM OF ONE (1) EIGHT (8) HOUR SHIFT, OR THE EQUIVALENT THEREOF FOR WHICH HE/SHE HAS RECEIVED
A WAGE.

Is employee currently working at your facility ? Yes _____ No_____

If "No" is marked, date last worked at your facility: _____

FOR HOME HEALTH ONLY

Please enter the number of hours of inservice education you have provided to this applicant for each of the past two years.

1st Year	2nd Year
_____	_____

_____ _____

Authorized Signature (Administrator / D.O.N. / Staff Development Coordinator) Date

Rev. 12/04